

**STATE OF CONNECTICUT
State Innovation Model**

2016 Proof of Solution for Quality Measure Production

Introduction	The Quality Council has requested that the HIT Council design a proof of solution to support the production of EHR based measures to support commercial and Medicaid value-based payment. The proof of solution should initially focus on selected measures (NQF 0059 - Diabetes Mellitus: Hemoglobin A1C Poor Control (>9%) and NQF 0018 - Controlling high blood pressure) that have been recommended by the Quality Council for inclusion in the multi-payer common measure set. The design should incorporate the core IT components (edge server indexing, metrics calculation, data/communication exchanges and scorecards) with the above filtering capabilities. (See attached high level specifications.)
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Stage 1: Quality Measure Production

Narrative:	<p>Our request for the first stage of this initiative is the production of measures of provider performance that can be used by all payers as the basis for shared savings distribution. At a minimum this requires measurement of the provider’s performance (advanced network or FQHC) for all patients attributed to that provider by each payer, in aggregate and stratified by race/ethnicity. It is assumed that a) all measures are eCQM measures that can be produced by any ONC certified EHR, b) providers are responsible for developing their own analytic methods to inform continuous quality improvement, and c) that all measures and any associated data are de-identified. End users for stage 1 will include:</p> <ol style="list-style-type: none"> 1) PMO – generates the aggregated reports and posts appropriate information to inform a consumer view of provider quality 2) Payer – reliable and valid performance data for use by all payers in value-based payment scorecard and shared savings distribution 3) Provider – performance information for use in monitoring progress over time and informing areas for focused improvement
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Key Dates and Actions:	<table border="1" style="width: 100%;"> <tr> <td style="width: 25%;">March 4</td> <td>Quality Council review of inter-council memo, update and approval</td> </tr> <tr> <td>March 4-20</td> <td>Presentation of the request to the HIT Council design group to flesh out design</td> </tr> <tr> <td>March 20</td> <td>Presentation of the request to the HIT Council w/design group comments</td> </tr> <tr> <td>April 1 through June 15</td> <td>SIM CTO and Chartis subject matter experts will complete draft design in consultation with HIT Council design group</td> </tr> <tr> <td>June 19th</td> <td>Design is presented to HIT and Quality Councils for final review and recommendation</td> </tr> <tr> <td>June 2015</td> <td>Joint presentation to Healthcare Innovation Steering Committee for decision</td> </tr> </table>	March 4	Quality Council review of inter-council memo, update and approval	March 4-20	Presentation of the request to the HIT Council design group to flesh out design	March 20	Presentation of the request to the HIT Council w/design group comments	April 1 through June 15	SIM CTO and Chartis subject matter experts will complete draft design in consultation with HIT Council design group	June 19 th	Design is presented to HIT and Quality Councils for final review and recommendation	June 2015	Joint presentation to Healthcare Innovation Steering Committee for decision
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**STATE OF CONNECTICUT
State Innovation Model**

<p>Assumptions, issues and questions:</p>	<ul style="list-style-type: none"> • Analysis will be done by the design group from the HIT council and the CTO. Presentations will be made to both councils for review and input. • Based on the technical team feedback there will be further discussions about issues and requirements that cannot be met using the proposed Edge server solution.
<p>Additional Specifications:</p>	<ol style="list-style-type: none"> 1. A technical resource will be needed to complete several of the work stream steps for the design. At this time, the person has not been hired. 2. Input and output requirements: <ul style="list-style-type: none"> ○ Input - Metric names, calculations and data sources (see attached) ○ Output - Reporting requirements – numerator and denominator <ul style="list-style-type: none"> ▪ Metric reporting – full panel ▪ Metric reporting – by payer/attributed population ○ Metric reporting by race/ethnicity
<p>Stage 2: Bi-directional Analytics</p>	
<p>Narrative:</p>	<p>Our request for stage 2 of this initiative to allow for additional data, introduce analytics capabilities and to conduct reporting at the level of the individual clinician focused on driving improvement in care delivery. The additional data and reporting capabilities are listed in the additional specifications section. This stage will require new analytic functionality, new technology and resources to support central and site-specific measure querying and the production of dashboards and reports.</p> <p>End users in stage 2 will include:</p> <ol style="list-style-type: none"> 1) Providers – detail review of their performance and ability to access SIM aggregated reports 2) Payers – Reports by payer and in total 3) PMO – generates aggregated reports 4) Consumers – TBD <p>Collaboratively the Design Group with the inclusion of Quality Council representation will document stage 2 options that include the requirements that are met, not met, additional costs, timeframe, resources. The options and the recommendation will be presented to the HIT Council for discussion and recommendation and then taken to the HISC for final decision.</p>
<p>Additional Specifications:</p>	<ol style="list-style-type: none"> 1. Input and output requirements: <ul style="list-style-type: none"> ○ Input - Metric names, calculations and data sources (see attached) ○ Output - Reporting requirements <ul style="list-style-type: none"> ▪ Reporting aggregation options (payer): <ul style="list-style-type: none"> • Cross payer all population (not just the attributed pop) • Ability to limit to attributed population by individual payer – individual commercial health plans, Medicare and Medicaid • Ability to pool payers as needed for specific metrics (e.g. hypertension control) ▪ Reporting analytic options (clinical/program to support CQI): <ul style="list-style-type: none"> • Metric reporting by individual clinician or practice within advanced network/FQHC

**STATE OF CONNECTICUT
State Innovation Model**

	<ul style="list-style-type: none">• Metric reporting by member residence/geo-code• Metric reporting by race/ethnicity/primary language/gender▪ Metric reporting by other specified patient characteristics (e.g., co-morbidities)
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State Innovation Model

NQF 0059

Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

STEWARD: National Committee for Quality Assurance

Measure Description:

The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.

Numerator Statement:

Patients whose most recent HbA1c level is greater than 9.0% or is missing a result, or for whom an HbA1c test was not done during the measurement year. The outcome is an out of range result of an HbA1c test, indicating poor control of diabetes. Poor control puts the individual at risk for complications including renal failure, blindness, and neurologic damage. There is no need for risk adjustment for this intermediate outcome measure.

Denominator Statement:

Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.

Exclusions:

Exclusions (optional):

-Exclude patients who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year.

AND

-Exclude patients who meet either of the following criteria:

-A diagnosis of polycystic ovaries, in any setting, any time in the patient's history through December 31 of the measurement year.

-A diagnosis of gestational or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.

Risk Adjustment:

No

Classification:

National Quality Strategy Priorities:

Effective Communication and Care Coordination

Use in Federal Program:

Meaningful Use Stage 2 (EHR Incentive Program) - Eligible Professionals, Medicare Shared Savings Program, Physician Quality Reporting System (PQRS)

Actual/Planned Use:

Payment Program, Professional Certification or Recognition Program, Public Reporting, Quality Improvement (Internal to the specific organization), Quality Improvement with Benchmarking (external benchmarking to multiple organizations), Regulatory and Accreditation Programs

Care Setting:

Ambulatory Care: Clinician Office/Clinic

Condition:

Endocrine, Endocrine: Diabetes

Cross-Cutting Area:

Data Source:

Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Laboratory, Electronic Clinical Data: Pharmacy, Paper Medical Records

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Level of Analysis:

Clinician: Group/Practice, Clinician: Individual, Health Plan, Integrated Delivery System, Population: National, Population: Regional, Population: State

Measure Type:

Outcome

Target Population:

Populations at Risk

Measure Steward Contact Information:

For additional measure specification information, please contact the Measure Steward.

Organization Name:

National Committee for Quality Assurance

Email Address:

nqf@ncqa.org

Website URL:

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NQF 0018

Controlling High Blood Pressure

STEWARD: National Committee for Quality Assurance

Measure Description:

The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.

Numerator Statement:

The number of patients in the denominator whose most recent BP is adequately controlled during the measurement year. For a patient's BP to be controlled, both the systolic and diastolic BP must be <140/90 (adequate control). To determine if a patient's BP is adequately controlled, the representative BP must be identified.

Denominator Statement:

Patients 18 to 85 years of age by the end of the measurement year who had at least one outpatient encounter with a diagnosis of hypertension (HTN) during the first six months of the measurement year.

Exclusions:

Exclude all patients with evidence of end-stage renal disease (ESRD) on or prior to the end of the measurement year. Documentation in the medical record must include a related note indicating evidence of ESRD.

Documentation of dialysis or renal transplant also meets the criteria for evidence of ESRD.

Exclude all patients with a diagnosis of pregnancy during the measurement year.

Exclude all patients who had an admission to a non-acute inpatient setting during the measurement year.

Risk Adjustment:

No

Classification:

National Quality Strategy Priorities:

Prevention and Treatment of Cardiovascular Disease

Use in Federal Program:

Actual/Planned Use:

Payment Program, Public Reporting, Quality Improvement (Internal to the specific organization), Regulatory and Accreditation Programs

Care Setting:

Ambulatory Care: Clinician Office/Clinic, Ambulatory Care: Urgent Care

Condition:

Cardiovascular, Cardiovascular: Hypertension

Cross-Cutting Area:

Data Source:

Administrative claims, Electronic Clinical Data, Paper Medical Records

Level of Analysis:

Health Plan, Integrated Delivery System

Measure Type:

Outcome

Target Population:

Populations at Risk, Senior Care

STATE OF CONNECTICUT State Innovation Model

Measure Steward Contact Information:

For additional measure specification information, please contact the Measure Steward.

Organization Name:

National Committee for Quality Assurance

Email Address:

nqf@ncqa.org

Website URL:

<http://www.ncqa.org/tabid/59/Default.aspx>

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